Great-West

Please complete this form in blue or black ink.

MAIL ALL CLAIMS TO:
GREAT-WEST LIFE & ANNUITY INS. CO.
1000 GREAT-WEST DRIVE
KENNETT, MO 63857-3749

HEALTH INSURANCE CLAIM FORM

Patient and Insured Information

1. Patient's Name (Last Name, First Name, Middle Initial)	7. Is There Another Health Benefit Plan? ☐ Yes ☐ No	9. Employee's I.D. Number or Social Security No.
2. Patient's Birthdate MM DD YY Sex ☐ M ☐ F	a. Other Insured's Name (Last Name, First Name)	10. Employee's Name (Last Name, First Name, Middle Initial)
3. Patient Relationship To Insured Self ☐ Spouse ☐ Child ☐ Other ☐	b. Other Insured's Birthdate MM DD YY Sex ☐ M ☐ F	11. Employee's Address (Street)
4. If Child Is Age 19 Or Over And A Full Time Student, Give Name And Address of School.	c. Employer's Name and Phone Number	a. City / b. State
	d. Other Insurance Policy No. & Name	c. Zip Code / d. Telephone (Include Area Code) ( )
5. Was Condition Related To Patient's Employment? ☐ Yes ☐ No	8. Are Natural Parents Divorced Or Separated? ☐ Yes ☐ No	12. Employee's Policy or Control No.
6. If Accident Related, Please Provide Date, Place, and How Injury Occurred.	a. Do You Have Custody? ☐ Yes ☐ No	13. Employer's Name or School Name
	b. Do You Have Court Ordered Financial Responsibility For Health Expenses? ☐ Yes ☐ No	**14. If This Plan is Secondary To Medicare Or Any Other Insurance Plan, Please Attach The Other Carrier Explanation Of Benefits.**
15. Patient's Or Authorized Person's Signature I authorize the release of any medical or other information necessary to process this claim. **NOTICE: See generic and state specific Anti-Fraud requirements on reverse side of this form.** Signature _____ Date _____		16. Insured's or Authorized Person's Signature I authorize payment of medical benefits to the undersigned physician or supplier for services described below. Authorization Does Not Extend To Benefits Payable For Services Completed After This Form is Released By Provider. Signed _____ Date _____

Physician or Supplier Information

17. Current Date MM DD YY Illness (First symptom) OR Injury (Accident) OR Pregnancy (LMP)	18. If Patient Has Had Same Or Similar Illness Give First Date MM DD YY	19. Dates Patient Unable to Work In Current Occupation From MM DD YY To MM DD YY
20. Name of Referring Physician Or Other Source a. I.D. Number of Referring Physician		21. Hospitalization Dates Related to Current Services From MM DD YY To MM DD YY

22. Diagnosis Or Nature Of Illness Or Injury. (Relate Items 1, 2, 3, or 4 To Item 23)

1. _____ 2. _____ 3. _____ 4. _____

Complete Section 23 Below or Attach an Itemized Bill

23. Date(s) of Service From MM DD YY To MM DD YY	Place Of Service	Type Of Service	Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT/HCPCS	Modifier	Diagnosis Code	$ Charges	Days of Units	Reserved For Local Use

24. Federal Tax I.D. SSN ☐ EIN ☐	25. Patient's Account No.	26. Total Charge $	27. Amount Paid $	28. Balance Due $

29. Signature of Physician Or Supplier Including Degrees or Credentials. NOTICE: See generic and state specific Anti-Fraud requirements on reverse side of this form. Signed Date	30. Name and Address of Facility Where Services Were Rendered (if other than home or office)	31. Physician's or Suppliers Name, Address Zip Code & Telephone No. PIN# GRP#

FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim containing false, incomplete or misleading information is guilty of criminal and/or civil offense. <u>This notice does not apply in VA. For the states of AZ, CA, FL, ID, NM, OR, PA, TN and TX, please refer to the following fraud notices.</u>

Arizona Fraud Notice:
Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Fraud Notice:
For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Florida Fraud Notice:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho Fraud Notice:
Any person who knowingly, and with intent to injure, defraud, or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony.

New Mexico Fraud Notice:
All claim forms and applications for insurance must contain the following disclosure:
"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties."

Oregon Fraud Notice:
Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any materially false, incomplete or misleading information maybe guilty of insurance fraud.

Pennsylvania Fraud Notice:
Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any false information or conceals for the purpose of misleading, information concerning and fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee Fraud Notice:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Texas Fraud Notice:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.